Department of State Health Services
Council Agenda Memo for State Health Services Council
February 26-27, 2014

Agenda Item Title: Amendments to rules and new rules concerning the collection and release of hospital outpatient emergency room data, hospital discharge data, and outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers

Agenda Number: 5.b

Recommended Council Action:

_____For Discussion Only

__X__For Discussion and Action by the Council

Background:

The Texas Health Care Information Collection program (THCIC) is housed in the Center for Health Statistics, within the division of the Chief Operating Officer. THCIC has been collecting inpatient discharge data since 1999 and outpatient surgical and radiological procedure data from hospitals and ambulatory surgical centers (ASCs) since October 2009. The data are used for analysis of health care quality and utilization by DSHS programs, such as the Cancer Registry and Birth Defects Registry, and by other health care researchers, other state agencies, and state universities.

THCIC currently collects administrative health care claims data from approximately 1000 health care facilities, (approximately 620 hospitals and approximately 381 ASCs) through a contracted vendor. THCIC also collects a limited Healthcare Effectiveness Data and Information Set from health maintenance organizations (approximately 33 service areas from 8 health plans).

The annual program budget is approximately $1.97 million of which the vendor contract is approximately $1,400,000 per year from General Revenue and data recoupment.

Summary:

The purpose of the amendments and new rules is to implement statutory requirements. Senate Bill 1, Article II DSHS, Rider 93, 83rd Legislature, Regular Session, 2013, provided instructions and funding for the collection of hospital emergency department data. Additionally, Senate Bill 7, 82nd Legislature, First Called Session, 2011, repealed the rural provider exemptions in Health and Safety Code, Chapter 108, effective September 1, 2014.

The proposed rules:

- clarify that "Hospital Emergency Department Claims" submitted to DSHS are not available to the public and shall not be released by DSHS;
- establish a list of revenue codes that indicate emergency room services, thereby identifying those patients' data as required to be submitted to DSHS and defining the data reporting requirements;
- align the data format, deadlines, and reporting process requirements with rules concerning the collection and release of outpatient surgical and radiological procedures at hospitals and ASCs; and
- modify language regarding exemptions and remove references to rural provider exemptions.

The proposed rules will provide the public with standardized data, reports, and information regarding the type of emergency department services, volume, average charges, and complexity of patient services provided by the hospitals. The data may assist policy makers and consumers in making informed decisions on health care issues regarding the types of services and the quality of care being provided by hospital emergency departments. Aligning outpatient data collection rules allows DSHS to utilize an existing system and contract and to reduce the burden on hospitals.

Key Health Measures:

The proposed new rules and amendments will provide hospitals with better information regarding which specific patients' data (based on revenue codes) are required to be submitted to DSHS, reducing the submission of extraneous data by facilities. Policy makers and researchers will have access to additional data for understanding the access and utilization of health care that occurs in hospital emergency rooms and in rural hospitals and rural ASCs.

It is anticipated that the collection of additional emergency department data and rural facility data will lead to an increase in the requests for data about the care and quality of care performed in those settings. THCIC will track the number of requests from DSHS programs, other state agencies, universities, and other researchers for public use and research data files. THCIC will also track access of reports developed from the additional data on the program website to identify trends in data use.

Summary of Input from Stakeholder Groups:

DSHS staff hold regular quarterly meetings with stakeholders that includes legislative, hospital, and ambulatory surgical center representatives; DSHS Council members; Texas Hospital Association, Texas Medical Association, Consumers Union, and Texas Association of Businesses members; industry vendors; and other interested persons. DSHS staff discussed issues regarding the collection of hospital emergency department data at the regular quarterly meetings held on June 27, 2013 and September 24, 2013.

Additionally requests for information were sent to some hospitals and data vendors that participate in the stakeholder group meetings to get feedback about any special requirements or restrictions that need to be considered for the rules. Based on stakeholder feedback, two other data elements were added to the amendments – Point of Origin (Source of Admission) and Patient Status.

DSHS anticipates the rules will be effective 90 days after they are adopted and published in the *Texas Register*. In order to reduce the burden on the effected health care facilities who will be transitioning to the federally mandated use of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Procedure Coding System (ICD-10-CM and ICD-10-PCS) on October 1, 2014, DSHS anticipates enforcing the new rules and amendments for emergency visit events and services performed by rural providers beginning January 1, 2015.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item **#5.b.**

Approved by Assistant Commissioner/Director:		Ed House		**Date:**	2/12/2014
Presenter:	Bruce Burns, D.C.	**Program:**	Texas Health Care Information Collection	**Phone No.:**	(512) 776-6431
Approved by CCEA:		Carolyn Bivens		**Date:**	2/12/2014

TITLE 25. HEALTH SERVICES
Part I. Department of State Health Services
Chapter 421. Health Care Information
Subchapter A. Collection and Release of Hospital Discharge Data.
Amendments §§421.1, 421.2, 421.5 and 421.8
Subchapter D. Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers
Amendments §421.62, §421.67 and §421.68
Subchapter E. Collection and Release of Hospital Outpatient Emergency Room Data
New §§421.71 - 421.78

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services department proposes amendments to §421.1, §421.2, §421.5, and §421.8, concerning the collection and release of hospital discharge data; amendments to §421.62, §421.67 and §421.68, concerning the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers; and new §§421.71 - 421.78, concerning the collection and release of hospital outpatient emergency room data.

BACKGROUND AND PURPOSE

The amendments to the hospital inpatient rules and hospital and ambulatory surgical center outpatient rules are necessary to comply with Senate Bill 7 (SB), §7.07(b) (82nd Legislature, First Called Session, 2011) and Health and Safety Code, Chapter 108. SB 7 mandated the repeal of Health and Safety Code, §108.002(18), §108.0025, and §108.009(c) regarding the rural provider definition and requirements for rural providers. The repeal of the rural provider language removes the ability for rural hospitals to request an exemption from reporting the required data elements for inpatients and outpatients (including patients seen in the emergency department). These amendments and new language will require all non-federal facilities to submit the required data. The bill language has an effective date of September 1, 2014. The earliest reporting of data for rural providers would begin with discharges that occur beginning October 1, 2014. The October 1, 2014, date coincides with the implementation date of the update to version ten of the International Classification of Diseases standard diagnostic codes (ICD-10-CM) and procedure codes (ICD-10-PCS). The implementation of the coding changes is a significant burden on all facilities and is critical to all processes and procedures relating to patient care, and billing, therefore the department anticipates implementing the data submission, correction and certification requirements on rural provider beginning January 1, 2015.

The new hospital outpatient emergency department data rules are necessary to comply with Senate Bill 1 (SB 1), Article II, Department of State Health Services, §93 (83rd Legislature, Regular Session, 2013) and Health and Safety Code, Chapter 108. SB 1 provided instructions and funding to the department to collect and release hospital emergency department data on an annual basis and report to the Legislative Budget Board, Governor, and Chairs of the Committees in each House with jurisdiction over public health issues. Language regarding rural

providers was removed in response to SB 7, which repeals the rural provider exemptions in Health and Safety Code, Chapter 108, §108.002(18), §108.0025, and §108.009(c), effective September 1, 2014. The department anticipates these rules will be effective for emergency visit event services that occur beginning January 1, 2015.

SECTION-BY-SECTION SUMMARY

Section 421.1, the term in paragraph (40) "Rural Provider" is deleted, and the remaining definitions are renumbered. Also, punctuation was added at the end of paragraph (12).

Section 421.2, Collection of Hospital Discharge Data, subsection (a), the phrase "as rural providers" is deleted from the last sentence.

Section 421.5, Exemptions from Filing Requirements, subsection (a)(1), the first sentence is amended by deleting the phrase "a rural provider or other" and inserting the word "an." Also, the sentence is amended by replacing the phrase "is a rural provider or other" with "shall be considered an" exempted provider. The second sentence is amended by changing it from "The department shall make a determination of which hospitals are entitled to this exemption at least annually and shall notify qualifying hospitals by publication in the *Texas Register* and by regular United States mail" to the following "The department shall make a determination of which hospitals are entitled to this exemption and shall notify hospitals by email or by regular United States mail." The third sentence is deleted. The fourth sentence deletes the phrase "based upon the most current data issued by the United States Bureau of the Census or changes in hospital ownership or management relationships." The fifth sentence replaces the phrase "rural providers or as other" with the word "an." Subsection (c) is amended by deleting the phrase "entitlement to an" from the sentence.

Section 421.8, Hospital Discharge Data Release, subsection (d), the second sentence is amended by replacing "in an aggregate form, without uniform patient, physician or other health professional identifiers, public use data relating to hospitals described in the Health and Safety Code, §108.0025(1) that are not rural providers because they do not meet the requirements of §108.0025(2)" with the following phrase "public use data that has the identities masked relating to hospitals that are low volume providers to protect the confidentiality and privacy of the patients, physicians and other health professionals."

Section 421.62, Collection of Hospital Outpatient and Ambulatory Surgical Center Data, subsection (a) second sentence, the reference to"§108.0025" is replaced by "Chapter 108."

Section 421.67, Event Files--Records, Data Fields and Codes, subsection (d), two data elements are added to the list of required data elements submitted on the modified ANSI 837 Institutional claim format: (38) "Point of Origin (Source of Admission) (Hospital Emergency Department Visits only)" and (39) "Patient Status (Hospital Emergency Department Visits only)." The second sentence in subsection (h) is deleted.

Section 421.68, Event Data Release, subsection (g)(10), the following data elements were added to the list of data elements included in the public use data file: (YYY) "Point of Origin (Source

of Admission) (Hospital Emergency Department Visits only)" and (ZZZ) "Patient Status (Hospital Emergency Department Visits only)." The last sentence in subsection (h) is deleted.

Section 421.71, defines the terms necessary for clarification of required processes and procedures to fulfill the legislative mandate.

Section 421.72, Collection of Outpatient Emergency Visit Data, establishes which facilities and which patients within those facilities are required to submit the required data elements to the department.

Section 421.73, Schedule for Filing Event Files, establishes the beginning date for filing of all emergency visit event data and references the schedule listed in §421.63(a)(1) - (4) of this title (relating to Schedules for Filing Event Files) concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers. The data will be submitted, processed and certified using the same outpatient data system; therefore the schedules will be the same. The effective date of the rule will be 90 calendar days after the rule is published in the *Texas Register*.

Section 421.74, Instructions for Filing Event Files, establishes the instructions for filing event files by referencing §421.64(a) and (b) of this title (relating to Instructions for Filing Event Files) concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers. The data will be reported using the same system, therefore the instructions for filing event files is the same.

Section 421.75, Acceptance of Event Files and Correction of Data Content Errors, establishes the criteria for event file acceptance and correction of data that appear to be in error by referencing §421.65 of this title (relating to Acceptance of Event Files and Correction of Data Content Errors) concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers, which will utilize the same process. Section 421.76, Certification of Compiled Event Data, establishes the process of certifying the accuracy and completeness of the emergency visit event data by referencing §421.66(a) - (f) of this title (relating to Certification of Compiled Event Data) concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers, which will utilize the same process. Section 421.77, Event Files--Records, Data Fields and Codes, establishes the event file, records data fields and codes to be used for emergency visit event data submissions. The file format, data field names, and the emergency visit revenue codes are listed. A statement regarding the effective date of the rule is 90 calendar days after the rule is published in the *Texas Register*.

Section 421.78, Outpatient Emergency Visit Event Data Release, establishes guidelines for the department regarding the release of the data collected under this subchapter. The section includes: language regarding the submitted records and public requests for data; the creation of codes and identifiers to protect patient and physician confidentiality; language that data use agreements are to be followed; language requiring the department to implement the confidentiality provisions of Health and Safety Code, Chapter 108; language to clarify that the data files are not to be considered provider quality data as specified in Health and Safety Code,

§108.010; language specifying a list of modifications to be made to the outpatient emergency visit event public use data file to protect patient and physician confidentiality and privacy and a list of the data elements to be included in data file; language establishing criteria for the release of the public use data files; and language establishing criteria for release of outpatient emergency visit event research data file.

FISCAL NOTE

Nagla Elerian, M.S., Director, Center for Health Statistics, has determined that for each calendar year of the first five years that the sections are in effect, there will be fiscal implications to the state as a result of enforcing or administering the sections as proposed. The anticipated costs on state government to implement the new and amended rules are $152,013. The department's contract cost increases include a one-time cost $5,000 for emergency department indicators to the outpatient records and recurring additional processing and helpdesk costs of $33,293 (total of $38,293) for the first year and $27,591, $28,143, $28,706 and $29,280 for the subsequent years (which includes a contracted two percent annual increase). The higher first year costs are due to anticipated increase in helpdesk activity and functions due to the rural providers beginning to submit data. This additional cost is an additional $12,484 helpdesk cost above the yearly of $12,484. The state-owned hospitals were contacted and cost estimates were requested, four state owned facilities responded and all indicated that they would not incur any additional costs to comply with the proposed new rules or the proposed amendments. The other state facilities provided no estimate of costs.

The fiscal implications for local governments that own or operate hospitals or ambulatory surgical centers will vary. The costs are dependent on the complexity of the hospital's or ambulatory surgical center's information technology, or their contract requirements with any vendors involved in their information systems process. The facilities that submit all their outpatient data, would incur no additional costs. The department's contract vendors system would filter out the claims that do not have the appropriate revenue codes or the appropriate procedure codes, those records would not be entered into the system. No local government entities responded to the cost estimate request. The department estimates that costs for local government entities may range from no additional costs up to a $44,996 for the first five years of implementation. This cost estimate is based on the statewide average salary of from the Texas Workforce Commission website on wages for SOC 29-2071 Medical Records and Health Information Technicians ($17.31) working 120 hours a quarter to submit and or review the additional emergency department data time four quarters per year. Therefore, the first year cost of $8,307 with annual increase of four percent being $8,640, $8,985, $9,345 and $9,719.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS AND ECONOMIC IMPACT TO PERSONS

Ms. Elerian anticipates that those hospitals or ambulatory surgical centers which are required to report under Health and Safety Code, Chapter 108, and these proposed new rules and amended rule sections may or may not incur costs dependent upon the complexity of their information technology systems or their data submission process (some facilities submit all their outpatient data, therefore, would incur no additional costs). Ambulatory surgical centers already reporting

to the department will incur no additional costs. Hospitals and ambulatory surgical centers that create a separate data claims for the department that is different from their billing systems, or do not submit data electronically, will incur additional costs dependent on the complexity of their information technology system. Hospitals that continue to sort out data by revenue codes may incur a small cost (dependent upon their system design) in updating their system to include the additional emergency department data. Rural provider facilities qualify as a small business or micro-business that have not been submitting data to the department may or may not incur any additional costs to implement the proposed new rules and proposed amendments. Twenty-four facilities that potentially meet the criteria of a small business or micro-business were contacted, two of those were also rural providers and additional eight rural hospitals and the one rural ambulatory surgical center was contacted for cost estimates, seven of those facilities responded, and only one stated they would have additional costs to implement the proposed new rules and the proposed amended sections. The one health care facility stated they would need to hire one extra Registered Nurse (RN) to work four to five days per month at a rate of $35 per hour in order to collect the needed information to submit to the department. The first five year cost estimate would be $90,992. This five year total is based on the previous stated amounts ($35 per hour times 5 days a month times 12 months with a four percent annual increase: $16,800 for the first year and $17,472, $18,170, $18,897 and $19,653 for the subsequent years.

The department estimates the number of hospitals and ambulatory surgical centers that may be affected by the proposed rules and proposed amendments that are small businesses (for-profit, independently owned, and under 100 employees or under $6 million in annual gross receipts) is approximately five hospitals and one ambulatory surgical center.

The department estimates that the number of hospitals and ambulatory surgical centers that are small businesses is approximately five hospitals and 96 ambulatory surgical centers. The department is not aware of any hospitals (not including rural hospitals) that are micro-businesses (for-profit, independently owned, and under 20 employees). The department believes that the number of ambulatory surgical centers that are micro-businesses is approximately 293.

Ms. Elerian anticipates that the five small business hospitals and a single micro-business ambulatory surgical center (affected by the proposed new rules and proposed amended sections) that would be required to submit new data will either submit all inpatient and outpatient data or will modify their computer systems to sort, capture and submit the required data according to the rules and the proposed amendments. Or the hospitals and ambulatory surgical centers that contract with a vendor or have built a computer system that is separate from their billing system may incur varying costs if they choose to modify their system to extract only the data for patients that are required to be submitted for their facilities. The costs depend upon the complexity of their systems and contract requirements with any vendors involved with the hospitals' or ambulatory surgical centers' information technology systems for sorting and submitting the data.

The department considered alternative methods of achieving the purposes of the proposal. The purposes of the sections could be broadly stated as enhancing the ability of the state and the department to collect data for analysis to assist the policy makers, researchers, and the public in making informed decisions or choices regarding access, utilization and quality of care provided

in hospitals and ambulatory surgical centers located in rural areas and during emergency visit services to hospital-based emergency departments.

One alternative to collecting data from rural area hospitals and ambulatory surgical centers would be to continue as is and not collect inpatient or outpatient data from the rural area hospitals and ambulatory surgical centers. This alternative would not provide the state, policy makers, researchers or the public with information regarding the healthcare utilization or access to care or information about quality of care provide in rural hospitals or ambulatory surgical centers. Therefore, state and local governmental entities could not decide on which types of health care services are needed for their respective jurisdictions. This alternative was not accepted, since it does not provide any additional information regarding healthcare utilization, access to care or quality of care in rural hospitals or ambulatory surgical centers.

Another alternative to collecting data from rural area hospitals and ambulatory surgical centers would be to collect the claims data for rural hospitals or ambulatory surgical centers through third party health plans. This alternative would reduce the burden on rural hospitals and rural ambulatory surgical centers and would provide the state, policy makers, researchers or the public with additional information about some of the care provided in rural hospitals and rural ambulatory surgical centers. This alternative would, however, require legislative authorization to collect claim data from health plans. This alternative would reduce some department contract cost for helpdesk activities in dealing with health plans rather than rural hospitals and rural ambulatory surgical centers or their information system contractors. The state would not be able to ascertain the number of uninsured and self-pay patients since hospitals and ambulatory surgical centers do not submit claims to health plans for those patients. Also, health plans would not be able to process the racial and ethnicity background codes required to be collected under Health and Safety Code, §108.009(k), because the health plans must abide by the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) and its subsequent revisions which require standard claim submissions formats in the American National Standards Institute, Accredited Standards Committee X12N, 837 Health Care Institutional Claim Implementation Guide, which does not have an approved data field for the collection of those data elements. The data required by health plans in their data submissions are not checked in the same manner by each health plan and in addition to legislative approval patient authorization would be required to receive this data from the health plans. The state would also not be authorized to collect the data from health plans that are located outside of Texas borders that are not regulated by Texas law, therefore reducing the amount of data collected. This alternative was not accepted, because this would provide inconsistent data.

A third alternative to collecting data from rural area hospitals and ambulatory surgical centers would be to allow the rural hospitals and rural ambulatory surgical centers to submit their claims data, as required by HIPAA, without racial and ethnic information mandated by Health and Safety Code, §108.009(k). This would reduce the burden on some of the rural hospitals and rural ambulatory surgical centers on having to collect, store, submit and certify the two additional codes which are not part of the HIPAA compliant Accredited Standards Committee X12N, 837 Health Care Institutional Claim Implementation Guide (ANSI 837 Institutional) format or the Accredited Standards Committee X12N, 837 Health Care Professional Claim Implementation Guide (ANSI 837 Professional) format for claims submission. This alternative would reduce the

data quality of the dataset for those data elements which are required by rule and are indicated as situational under the ANSI 837 Institutional or ANSI 837 Professional technical specification requirements. This alternative would require a department contractor to modify audits and require department staff and researchers to be more cognizant to missing data where the data formats do not completely agree. This would make the dataset less valued for these inconsistencies. This alternative was not accepted because of the inconsistency in data submission requirements and the lack of reporting ethnic data.

One alternative to collecting hospital based emergency department data would be to not collect the required revenue code list for emergency visit services as proposed by these sections; in other words, not propose or adopt the new sections. Under that alternative, the department would continue to collect the inpatient hospital data and outpatient data that it currently collects. While this alternative would provide the public with the current data to help the public make choices, it would not provide a statewide view of emergency visit access, utilization of those emergency services, (including those individuals with mental health diagnoses or substance abuse diagnoses) or information about emergency services that could potentially be prevented if the data were reported to the department. Therefore, state and local governmental entities could not decide on which types of health care services are needed for their respective jurisdictions. This alternative was not accepted.

Another alternative to collecting hospital based emergency department data would be to collect all hospital outpatient data and ambulatory surgical center outpatient data in §§421.61 - 421.68 of this title concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers rules. While this alternative would provide the public with the best and most comprehensive set of data to help the policy makers, researchers and the public to make choices regarding emergency visits and outpatient services from hospitals and ambulatory surgical centers, it is not fiscally feasible. This alternative, which is authorized by Health and Safety Code, Chapter 108, would require the department to collect and process over 40 million outpatient records a year versus the estimated 17 million outpatients (including the additional 7 million emergency visits not reported by hospitals either through §§421.1 - 421.10 of this title concerning the Collection and Release of Hospital Discharge Data and §§421.61 - 421.68 concerning the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers. This alternative would increase the contracted costs beyond the Texas Legislature appropriated funds for the proposed additional emergency department data collection and analysis. This alternative was not accepted.

A third alternative to collecting hospital based emergency department data would be to propose a set of specific procedure codes of the most commonly used in outpatient emergency visits and collect data based on those codes, rather than revenue codes. In meetings and discussions with stakeholders representing hospitals, the stakeholders requested that the department use revenue codes because of the relative stability of those codes and noted that procedure codes are not specific to outpatient emergency visits. The use of procedure codes would meet most of the purposes of these sections, but may miss some procedures or patients that were in the emergency department. This alternative may require frequent updates of the procedures in the rules and would require more resources from a department's contractor and the providers in filtering out the required patient records required to be submitted, corrected and certified. The alternative of

using procedures codes was not accepted because of the stated preference of the stakeholders and the disadvantages noted previously.

IMPACT ON LOCAL EMPLOYMENT

There is no anticipated negative impact on local employment.

REGULATORY ANALYSIS

The department has determined that the proposed rules are not "major environmental rules" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. The proposed rules are not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed rules do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC BENEFIT

Ms. Elerian has also determined that for each year of the first five years the sections are in effect, the public will benefit from the adoption of the proposed rules. The public benefit anticipated as a result of collecting and reporting of this data is the ability to provide the public with data and information regarding the type of emergency visit services, volume, average charges, and the complexity of patient services provided by the hospitals. The public will benefit from health care provider reports and information about the quality of care being provided by rural hospitals and rural ambulatory surgical centers and by hospital emergency departments. The standardized data and the reports and information developed by the department from the data will assist the policymakers, researchers and consumers in making informed decisions on healthcare issues involving hospital emergency department services.

PUBLIC COMMENT

Comments on the proposal may be submitted to Bruce M. Burns, D.C., Center for Health Statistics, Department of State Health Services, Mail Code 1898, P.O. Box 149347, Austin, Texas 78714-9347, Fax (512) 458-7740. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments and new sections are authorized by Health and Safety Code, §108.006, §108.009, §108.010, §108.011 and §108.013, which require the Executive Commissioner to adopt rules necessary to carry out Chapter 108 including rules on data collection requirements, to prescribe the process of data submission, to implement a methodology to collect and disseminate data reflecting provider utilization and quality, to specify data elements to be required for submission to the department and which data elements are to be released in hospital inpatient stays, hospital and ambulatory surgical center outpatient visits including hospital emergency department visit data in public use data files; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The amendments and new sections affect Health and Safety Code, Chapters 108 and 1001; and Government Code, Chapter 531.

Legend: (Proposed amendments)
Single Underline = Proposed new language
[Bold Print, and Brackets] = Current language proposed for deletion
Regular Print = Current language
(No change.) = No changes are being considered for the designated subdivision

SUBCHAPTER A. COLLECTION AND RELEASE OF HOSPITAL DISCHARGE DATA

§421.1. Definitions. The following words and terms, when used in this subchapter **[chapter]**, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (11) (No change.)

(12) DRG--Diagnosis Related Group.

(13) - (39) (No change.)

[(40) Rural provider--A health care facility located in a county with a population of not more than 35,000 as of July 1 of the most recent year according to the most recent United States Bureau of the Census estimate; or located in a county with a population of more than 35,000 but with 100 or fewer licensed hospital beds and not located in an area that is delineated as an urbanized area by the United States Bureau of the Census; and is not state owned, or not managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals. A health care facility is not a rural provider if an individual or legal entity that manages or owns one or more other hospitals owns or controls more than 50% of the voting rights with respect to the governance of the facility.]

(40) **[(41)]** Service Unit Indicator--An indicator derived from submitted data (based on Bill type or Revenue Codes) and represents the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit or Skilled Nursing Unit) where the patient received treatment.

(41) **[(42)]** Severity adjustment--A method to stratify patient groups by degrees of illness and mortality.

(42) **[(43)]** Submission--The transfer of a set of computer records as specified in §421.9 of this title that constitutes the discharge report for one or more hospitals.

(43) **[(44)]** Submitter--The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to the department. A submitter may be a hospital or an agent designated by a hospital or its owner.

(44) **[(45)]** THCIC Identification Number--A string of six characters assigned by the department to identify health care facilities for reporting and tracking purposes.

(45) **[(46)]** Uniform facility identifier--A unique number assigned by the department to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the department will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information.

(46) **[(47)]** Uniform patient identifier--A unique identifier assigned by the department to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and inpatient admissions. The relationship of the identifier to the patient-specific data elements used to assign it is confidential.

(47) **[(48)]** Uniform physician identifier--A unique identifier assigned by the department to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(48) **[(49)]** Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

§421.2. Collection of Hospital Discharge Data.

(a) All hospitals in operation for all or any of the reporting periods described in §421.3 of this title (relating to Schedule for Filing Discharge Reports) shall submit discharge claims as specified in §421.9 of this title (relating to Discharge Reports--Records, Data Fields and Codes) on all discharged inpatients to the department. To the extent the admission, treatment, or discharge is made by a health professional, other than a physician, data elements specified in §421.9(d)(36) - (41) of this title shall be filled accordingly or data elements (38) or (41) shall be marked with one of the department approved temporary "Physician" or "Other health professional" code numbers and data elements (36)(A) - (C) or (39)(A) - (C) may be left blank. Hospitals owned by the federal government and hospitals exempted **[as rural providers]** may submit hospital discharge claim.

(b) - (g) (No change.)

§421.5. Exemptions from Filing Requirements.

(a) Types of Exemptions.

(1) Exemption as an **[a rural provider or other]** exempted provider. All hospitals except those owned by the federal government shall submit discharge reports to the department unless the department determines that the hospital shall be considered an **[is a rural provider or other]** exempted provider. The department shall make a determination of which hospitals are entitled to this exemption **[at least annually]** and shall notify **[qualifying]** hospitals

by email or **[publication in the *Texas Register* and]** by regular United States mail. **[Hospitals which are not initially given an exemption may apply for an exemption.]** This exemption, if granted, may be revoked by the department should the hospital cease to meet the criteria for exemption **[based upon the most current data issued by the United States Bureau of the Census or changes in hospital ownership or management relationships]**. Hospitals that cease to be exempted as an **[rural providers or as other]** exempted provider shall be responsible for submitting discharge claims on all discharges that occur 30 days after loss of the exemption. The initial discharge report shall not be due until 90 days after notice is given. Subsequent discharge reports are due as specified in 421.3(a) of this title (relating to Schedule for Filing Discharge Reports).

(2) (No change.)

(b) (No change.)

(c) Reporting loss of exemptions. Hospitals shall notify the department in writing within 30 days of their loss of an **[entitlement to an]** exemption authorized by subsection (a) of this section.

§421.8. Hospital Discharge Data Release.

(a) - (c) (No change.)

(d) Release of public use data files. The department shall release public use data that has the identities masked relating to hospitals that are low volume providers to protect the confidentiality and privacy of the patients, physicians and other health professionals **[in an aggregate form, without uniform patient, physician or other health professional identifiers, public use data relating to hospitals described by the Health and Safety Code, §108.0025(1) that are not rural providers because they do not meet the requirements of §108.0025(2)]**.

(e) - (l) (No change.)

SUBCHAPTER D COLLECTION AND RELEASE OF OUTPATIENT SURGICAL AND RADIOLOGICAL PROCEDURES AT HOSPITALS AND AMBULATORY SURGICAL CENTERS

§421.62. Collection of Hospital Outpatient and Ambulatory Surgical Center Data.

(a) Each facility in operation for all or any of the reporting periods described in §421.63 of this title (relating to Schedule for Filing Event Files) shall submit to DSHS event claims as specified in §421.67 of this title (relating to Event Files--Records, Data Fields and Codes) on all patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or **[§421.67]**(g) of this title. All facilities that are exempt under the Health and Safety Code, Chapter 108 **[§108.0025]**, but choose to participate in reporting under this subchapter, shall comply with the requirements in this subchapter. To the extent the medical

screening examination, triage, observation, diagnosis or treatment is made by a health professional, other than a physician, data elements specified in §421.67(d)(25) - (30) or (e)(19) of this title shall be filled accordingly or data elements in §421.67(d)(26) or (29) in the modified ANSI 837 Institutional Guide or §421.67(e)(20) in the modified ANSI 837 Professional Guide shall be marked with one of DSHS approved temporary "Physician" or "Other health professional" code numbers and data elements in §421.67(d)(25)(A) - (C) or (28)(A) - (C) in the ANSI 837 Institutional Guide format or §421.67(e)(19)(A) - (C) in the ANSI 837 Professional Guide format may be left blank.

(b) - (f) (No change.)

§421.67. Event Files--Records, Data Fields and Codes.

(a) - (c) (No change.)

(d) Facilities shall submit the required minimum data set in the following modified ANSI 837 Institutional Guide format for all patients that are uninsured or considered self-pay or covered by third party payers in which the payer requires the claim be submitted in an ANSI 837 Institutional Guide format or CMS-1450 format for which an event claim is required by this subchapter. The required minimum data set for the modified (as specified in subsection (c) of this section) ANSI 837 Institutional Guide format includes the following data elements as listed in this subsection:

(1) - (36) (No change.)

(37) Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility;

(38) Point of Origin (Source of Admission) (Hospital Emergency Department Visits only); and

(39) Patient Status (Hospital Emergency Department Visits only).

(e) - (g) (No change.)

(h) This section is effective 90 calendar days after being published in the Texas Register. **[The department will not implement or enforce this section until September 1, 2011, at the earliest.]**

§421.68. Event Data Release.

(a) - (f) (No change.)

(g) Creation of public use data file. DSHS will create a public use data file by creating a single record for each reportable outpatient event and adding, modifying or deleting data elements in the following manner as listed in this subsection:

(1) - (9) (No change.)

(10) data elements to be included in the public use data file:

(A) - (VVV) (No change.)

(WWW) Service Line Non-Covered Charge Amount; **[and]**

(XXX) Patient Country (when the address is not in United States of America and confidentiality can be maintained);

(YYY) Point of Origin (Source of Admission) (Hospital Emergency Department Visits only); and

(ZZZ) Patient Status (Hospital Emergency Department Visits only).

(h) Release of public use data files. **[DSHS shall release in an aggregate form, without uniform patient, physician or other health professional identifiers, public use data relating to facilities described by the Health and Safety Code, §108.0025(1), that are not rural providers because they do not meet the requirements of Health and Safety Code, §108.0025(2).]**

(1) - (5) (No change.)

(i) No Change.

Legend: (Proposed New Rule(s))
Regular Print = Proposed new language

SUBCHAPTER E. COLLECTION AND RELEASE OF HOSPITAL OUTPATIENT EMERGENCY ROOM DATA.

§421.71. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Accurate and Consistent Data--Data that has been edited by DSHS and subjected to provider validation and certification.

(2) ANSI--American National Standards Institute.

(3) ANSI 837 Institutional Guide--American National Standards Institute, Accredited Standards Committee X12N, 837 Health Care Institutional Claim Implementation Guide.

(4) APC--Ambulatory Payment Classification.

(5) APG--Ambulatory Patient Group (APG)--A prospective payment system (PPS) for hospital-based outpatient care developed by 3M™. APGs provide information regarding the kinds and amounts of resources utilized in an outpatient visit and classify patients with similar clinical characteristics.

(6) Audit--An electronic standardized process developed and implemented by DSHS to identify potential errors and mistakes in file structure format or data element content by reviewing data fields for the presence or absence of data and the accuracy and appropriateness of data.

(7) Certification File--One or more electronic files (may include reports concerning the data and its compilation process) compiled by DSHS that contain one record for each patient event which has at least one procedure covered in the revenue codes specified in §421.77(e) of this title (relating to Event Files--Records, Data Fields and Codes) submitted for each facility under this subchapter during the reporting quarter and may contain one record for any patient event occurring during one prior reporting quarter for whom additional event claims have been received.

(8) Certification Process--The process by which a provider confirms the accuracy and completeness of the certification file required to produce the public use data file as specified in §421.76 of this title (relating to Certification of Compiled Event Data).

(9) Charge--The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules or write-offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization.

(10) Clinical Classifications Software--A classification system that groups diagnoses and procedures into a limited number of clinically meaningful categories developed at the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ).

(11) Comments--The notes or explanations submitted by the facilities, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively.

(12) CRG--Clinical Risk Grouping software which classifies individuals into mutually exclusive categories and, using claims data, assigns the patient to a severity level if they have a chronic health condition. Developed by 3M™ Corporation.

(13) Data format--The sequence or location of data elements in an electronic record according to prescribed specifications.

(14) DSHS--Department of State Health Services, the successor state agency to the Texas Health Care Information Council and the Texas Department of Health.

(15) EDI--Electronic Data Interchange--A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions.

(16) Electronic Filing--The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine track magnetic tape, computer diskette or other magnetic media acceptable to DSHS.

(17) Emergency Department--Department or room within a hospital or health care facility as determined by federal or state law for the provision of emergency health care services.

(18) Emergency Visit Patient or patient--For the purposes of this subchapter a patient who receives services in the emergency department or emergency room of the health care facility. Emergency Visit Patients include patients who receive one or more services covered by the revenue codes specified in §421.77(e) of this title, which may occur in the emergency department or emergency room of the healthcare facility.

(19) ESRD--End Stage Renal Disease.

(20) Error--Data submitted on an event file which are not consistent with the format and data standards contained in this subchapter or with auditing criteria established by DSHS.

(21) Ethnicity -The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non-Hispanic.

(22) Event--The medical screening examination, triage, observation, diagnosis or treatment of a patient within the authority of a facility that occurs as result of an outpatient emergency visit.

(23) Event claim--A set of computer records as specified in §421.77 of this title relating to a specific patient. "Event claim" corresponds to the ANSI 837 Institutional Guide term, "Transaction set."

(24) Event file--A computer file as defined in §421.77 of this title periodically submitted on or on behalf of a facility in compliance with the provisions of this subchapter. "Event File" that corresponds to the ANSI 837 Institutional Guide terms, "Communication Envelope" or "Interchange Envelope."

(25) Facility--For the purposes of this subchapter, a facility is a hospital required to report under the Health and Safety Code, Chapter 108 and this subchapter.

(26) Facility Type Indicators--An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that hospital (e.g., Acute Care Hospital, Children's Hospital, or Cancer Hospital, etc.). A facility may have more than one indicator.

(27) Geographic identifiers--A set of codes indicating the health service region and county in which the patient resides.

(28) HCPCS--Healthcare Common Procedure Coding System of the Centers for Medicare and Medicaid Services. This includes the "Current Procedural Terminology" (CPT) codes (maintained by the "American Medical Association" (AMA)), which are "Level 1" HCPCS codes.

(29) Hospital--A public, for-profit, or nonprofit institution licensed as a general or special hospital as defined in §133.2(21) of this title (relating to Definitions), or a hospital owned by the state.

(30) ICD--International Classification of Disease.

(31) Inpatient -- A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, subacute, skilled nursing, long-term, psychiatric, substance abuse, physical rehabilitation and all other types of hospital units.

(32) IRB--Institutional Review Board -- composed of DSHS' appointees or agents who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the outpatient emergency visit event public use data.

(33) Operating or Other Physician -- The "physician" licensed by the Texas Medical Board or "other health professional" licensed by the State of Texas who performed the surgical or radiological procedure most closely related to the principal diagnosis.

(34) Other health professional--A person licensed to provide health care services other than a physician. "Other health professional" is an individual other than a physician who provides diagnostic or therapeutic procedures to patients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the facilities to examine, observe or treat patients.

(35) Other Provider--For the purposes of reporting on the modified ANSI 837 Institutional Guide, the physician, other health professional or facility as reported on a claim, who performed a secondary surgical or a primary or secondary radiological procedure on the patient for the event, if they are not reported as the operating or other physician or the facility. In

the case where a substitute provider (locum tenens) is used, that physician or other health professional shall be submitted as specified in this subchapter.

(36) Outpatient Emergency Visit -- For the purposes of this subchapter, events associated with hospital services in an emergency department or emergency room.

(37) Patient account number--A number assigned to each patient by the facility, which appears on each computer record in a patient event claim. This number is not consistent for a given patient from one facility to the next, or from one admission to the next in the same facility. DSHS will delete or encrypt this number to protect patient confidentiality prior to release of data.

(38) Physician--An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151 et seq.

(39) Provider--For the purposes of this subchapter, a physician or facility.

(40) Public use data file--For the purposes of this subchapter, a data file composed of encounter or event claims which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of data imposed by statute.

(41) Race--A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Facilities shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other.

(42) Required minimum data set--The list of data elements for which facilities may submit an event claim for each patient event occurring in the facility. The required minimum data sets are specified in §421.77(d) of this title. This list does not include all the data elements that are required by the modified ANSI 837 Institutional Guide to submit an acceptable event file. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify or qualify subsequent data elements).

(43) Research data file--A customized data file, which may include the data elements in the public use file and may include data elements other than the required minimum data set submitted to DSHS, except those data elements that could reasonably identify a patient or physician, except as authorized by law.

(44) Submission--The transfer of a set of computer records as specified in §421.77 of this title that constitutes the event file for one or more reporting hospitals under this subchapter.

(45) Submitter--The person or organization, which physically prepares an event file for one or more facilities and submits them under this subchapter. A submitter may be a facility or an agent designated by a facility or its owner.

(46) THCIC Identification Number--A string of six characters assigned by DSHS to identify facilities for reporting and tracking purposes. For a facility operating multiple facility locations under one license number and duplicating services at those locations, the department will assign a distinguishable identifier for each separate facility location under one license number. The relationship of the identifier to the name and license number of the facility is public information.

(47) Uniform patient identifier--A unique identifier assigned by DSHS to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across facilities and patient events. The relationship of the identifier to the patient-specific data elements used to assign it is confidential.

(48) Uniform physician identifier--A unique identifier assigned by DSHS to a physician or other health professional who is reported as attending, operating or other provider providing health care services or treating a patient in a facility and which remains constant across facilities. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(49) Universal Resource Locator (URL) -- A specific set of ordered characters to identify a unique resource location (address) on the Internet or World Wide Web.

(50) Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

§421.72. Collection of Outpatient Emergency Visit Data.

(a) Each facility in operation for all or any of the reporting periods described in §421.73 of this title (relating to Schedule for Filing Event Files) shall submit to DSHS outpatient emergency visit event claims as specified in §421.77 of this title (relating to Event Files--Records, Data Fields and Codes) on all patients in which the patient received one or more emergency services covered by the revenue codes specified in §421.77(e) of this title. All facilities that are exempt under Health and Safety Code, Chapter 108, which choose to participate in reporting under this subchapter, shall comply with the requirements in this subchapter. To the extent the medical screening examination, triage, observation, diagnosis or treatment is made by a health professional other than a physician, data elements specified in §421.77(d)(25) - (30) of this title shall be filed accordingly or data elements in §421.77(d)(26) or (29) in the modified ANSI 837 Institutional Guide shall be marked with one of DSHS approved temporary "Physician" or "Other health professional" code numbers and data elements in §421.77(d)(28)(A) - (C) in the ANSI 837 Institutional Guide format may be left blank.

(b) All outpatient emergency visit events in which the patient received one or more of the emergency services covered by the revenue codes specified in §421.77(e) of this title shall be reported by the facility that prepares one or more bills for patient services. The facility shall submit an event claim corresponding to each bill containing the data elements required by §421.77 of this title. For all patients who received one or more emergency service covered by the revenue codes specified in §421.77(e) of this title for which the facility does not prepare a bill for

patient services, the facility shall submit an event claim containing the required minimum data set.

(c) Each facility shall submit event files by electronic filing unless the facility receives an exemption letter from DSHS.

(d) Each facility shall submit event claims and event files in the format specified in §421.77 of this title.

(e) Each facility shall submit event files, data certifications and other required information to DSHS or its agents at physical, universal resource locator (URL) addresses or telephonic addresses specified by DSHS. DSHS shall notify all facilities and submitters in writing and by publication in the *Texas Register* at least 30 calendar days before any change in the addresses.

(f) Each facility may submit event files, or may designate an agent to submit the event files. If a facility designates an agent, it shall inform DSHS of the designation in writing at least 30 calendar days prior to the agent's submission of any discharge report. The facility shall inform DSHS in writing at least 30 calendar days prior to changing agents or making the submissions itself.

§421.73. Schedule for Filing Event Files.

(a) For patient events occurring on or after January 1, 2015, as specified by DSHS, facilities shall file event files according to the schedule listed in §421.63(a)(1) - (4) of this title (relating to Schedule for Filing Event Files).

(b) This section is effective 90 calendar days after being published in the *Texas Register*.

§421.74. Instructions for Filing Event Files.

(a) Electronic Data Interchange. Event files may be filed electronically using methods and media as specified in §421.64(a) and (b) of this title (relating to Instructions for Filing Event Files).

(b) This section is effective 90 calendar days after being published in the *Texas Register*.

§421.75. Acceptance of Event Files and Correction of Data Content Errors.

(a) Upon receipt of an event file, DSHS shall use the established process specified in §421.65(a) - (c) of this title (Acceptance of Event Files and Correction of Data Content Errors).

(b) This section is effective 90 calendar days after being published in the *Texas Register*.

§421.76. Certification of Compiled Event Data.

(a) The chief executive officer or chief executive officer's designated agent of each facility shall certify the compiled event data as specified in §421.66(a) - (f) of this title (relating to Certification of Compiled Event Data).

(b) This section is effective 90 calendar days after being published in the *Texas Register*.

§421.77. Event Files--Records, Data Fields and Codes.

(a) Facilities shall submit event files electronically in the file format for outpatient bills defined by ANSI, commonly known as the ANSI ASC X12N form 837 Health Care Claims transaction for institutional claims. ANSI updates these formats from time to time by issuing new versions and the United States Department of Health and Human Services adopts regulations regarding HIPAA that update the version allowed for claim submissions.

(b) DSHS will make detailed specifications for these data elements available to submitters and to the public.

(c) In addition to the data elements contained in the ANSI 837 Institutional Guide, DSHS has specified the location where additional data elements shall be reported in the ANSI 837 Institutional Guide format. These are specified in §421.67(c) of this title (relating to Event Files--Records, Data Fields and Codes.)

(d) Facilities shall submit the required minimum data set in the following modified ANSI 837 Institutional Guide format for all patients that are uninsured or considered self-pay or covered by third party payers in which the payer requires the claim be submitted in an ANSI 837 Institutional Guide format for which an event claim is required by this subchapter. The required minimum data set for the modified (as specified in subsection (c) of this section) ANSI 837 Institutional Guide format includes the following data elements as listed in this subsection:

(1) Patient Name:

(A) Patient Last Name;

(B) Patient First Name; and

(C) Patient Middle Initial.

(2) Patient Address:

(A) Patient Address Line 1;

(B) Patient Address Line 2 (if applicable);

(C) Patient City;

(D) Patient State;

(E) Patient ZIP; and

(F) Patient Country (if address is not in United States of America, or one of its territories).

(3) Patient Birth Date;

(4) Patient Sex;

(5) Patient Race;

(6) Patient Ethnicity;

(7) Patient Social Security Number;

(8) Patient Account Number;

(9) Patient Medical Record Number;

(10) Claim Filing Indicator Code (primary and secondary);

(11) Payer Name - Primary and secondary (if applicable, for both);

(12) National Plan Identifier - for primary and secondary (if applicable) payers (National Health Plan Identification number, if applicable and when assigned by the Federal Government);

(13) Type of Bill (Facility Type Code plus Claim Frequency Code);

(14) Statement Dates;

(15) Principal Diagnosis;

(16) Patient's Reason for Visit;

(17) External Cause of Injury (E-Code) up to 10 occurrences (if applicable);

(18) Other Diagnosis Codes - up to 24 occurrences (all applicable);

(19) Occurrence Code - up to 24 occurrences (if applicable);

(20) Occurrence Code Associated Date - up to 24 occurrences (if applicable);

(21) Value Code - up to 24 occurrences (if applicable);

(22) Value Code Associated Amount - up to 24 occurrences (if applicable);

(23) Condition Code - up to 24 occurrences (if applicable);

(24) Related Cause Code - up to 3 occurrences (if applicable);

(25) Attending Physician or Attending Practitioner Name (if applicable):

(A) Attending Practitioner Last Name;

(B) Attending Practitioner First Name; and

(C) Attending Practitioner Middle Initial.

(26) Attending Practitioner Primary Identifier (National Provider Identifier) (if applicable);

(27) Attending Practitioner Secondary Identifier (Texas state license number) (if applicable);

(28) Operating Physician or Other Health Professional Name (if applicable):

(A) Operating Physician or Other Health Professional Last Name;

(B) Operating Physician or Other Health Professional First Name; and

(C) Operating Physician or Other Health Professional Middle Initial.

(29) Operating Physician or Other Health Professional Primary Identifier (National Provider Identifier) (if applicable);

(30) Operating Physician or Other Health Professional Secondary Identifier (Texas state license number) (if applicable);

(31) Total Claim Charges;

(32) Revenue Service Line Details (up to 999 service lines) (all applicable);

(A) Revenue Code;

(B) Procedure Code;

(C) HCPCS Procedure Modifier 1 (applicable to each submitted Procedure code);

(D) HCPCS Procedure Modifier 2 (applicable to each submitted Procedure code);

(E) HCPCS Procedure Modifier 3 (applicable to each submitted Procedure code);

(F) HCPCS Procedure Modifier 4 (applicable to each submitted Procedure code);

(G) Charge Amount;

(H) Unit Code;

(I) Unit Quantity;

(J) Unit Rate; and

(K) Non-covered Charge Amount.

(33) Service Line Date;

(34) Service Provider Name;

(35) Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier;

(36) Service Provider Address:

(A) Service Provider Address Line 1;

(B) Service Provider Address Line 2 (if applicable);

(C) Service Provider City;

(D) Service Provider State; and

(E) Service Provider ZIP; and

(37) Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility;

(38) Point of Origin (Source of Admission); and

(39) Patient Status.

(e) Facilities shall submit the required minimum data set to DSHS for each patient who has one or more of the following revenue codes in this subsection. Facilities operating in the State of Texas shall submit the required data elements as specified in subsection (d) of this section relating to the revenue codes in this subsection.

(1) 0450 Emergency Room-- General Classification;

(2) 0451 Emergency Room--EMTALA Emergency Medical Screening;

(3) 0452 Emergency Room--Emergency Room beyond EMTALA;

(4) 0456 Emergency Room--Urgent Care; and

(5) 0459 Emergency Room-- Other Emergency Room;

(f) This section is effective 90 calendar days after being published in the *Texas Register*.

§421.78. Outpatient Emergency Visit Event Data Release.

(a) DSHS records are public records under Government Code, Chapter 552, except as specifically exempted by Health and Safety Code, §§108.010, 108.011 and 108.013 or other state or federal law. Copies of such records may be obtained upon request and upon payment of user fees established by DSHS. Event claims in any format as submitted to DSHS are not available to the public and are exempt from disclosure pursuant to Health and Safety Code, §§108.010, 108.011 and 108.013, and shall not be released. Likewise, patient and physician identifying data collected by the DSHS through editing of facility data shall not be released.

(b) Creation of codes and identifiers. DSHS shall develop the following codes and identifiers, as listed in paragraphs (1) - (2) of this subsection, required for creation of the public use data file and for other purposes.

(1) DSHS shall create a process for assigning uniform patient identifiers, uniform physician identifiers and uniform other health professional identifiers using data elements collected. This process is confidential and not subject to public disclosure. Any documents or records produced describing the process or disclosing the person associated with an identifier are confidential and not subject to public disclosure.

(2) DSHS shall create a process for assigning geographic identifiers to each event record.

(c) Requests for outpatient emergency visit event data files, including data on one or more providers, are matters of public record and copies of all requests shall be maintained by DSHS in accordance with DSHS records retention schedule.

(d) All users including Texas state agencies that request outpatient event data shall abide by the data use agreement.

(e) DSHS shall establish procedures for screening all requests to assure that filling the request will not violate the confidentiality provisions of Health and Safety Code, Chapter 108.

(f) The data elements specified for outpatient emergency visit event reports in this section do not constitute "Provider Quality Data" as discussed in Health and Safety Code, §108.010.

(g) Creation of public use data file. DSHS will create a public use data file by creating a single record for each reportable outpatient emergency visit event and adding, modifying or deleting data elements in the following manner as listed in this subsection:

(1) delete patient and insured name, Social Security number, address and certificate data elements, any patient identifying information, and patient control and medical record numbers;

(2) convert patient birth date to age;

(3) convert procedure dates to a code for the day of the week;

(4) convert occurrence dates to day values;

(5) delete physician and other health professional names and numbers and assign a alphanumeric uniform physician identifier for the physicians and other health professionals who were reported as “Attending”, or "operating or other" on patients;

(6) assign codes indicating the primary and secondary sources of payment;

(7) the minimum cell size required by Health and Safety Code, §108.011(i)(2), shall be five, unless DSHS determines that a higher cell size is required to protect the confidentiality of an individual patient or physician;

(8) convert all procedure codes to HCPCS codes (in the version that is current for the date the data was due to be submitted or the version in effect at the date of service);

(9) add nationally accepted risk and severity adjustment scores utilizing an algorithm approved by DSHS, when available and applicable;

(10) data elements to be included in the public use data file:

(A) Event Year and Quarter;

(B) Provider Name (Facility Name);

(C) THCIC Identification Number;

(D) Facility Type Indicators;

(E) Patient Sex/Gender;

(F) Patient ZIP Code;

(G) County Code;

(H) Health Service Region Code;

(I) Patient State;

(J) Patient Race;

(K) Patient Ethnicity;

(L) Claim Type Indicator;

(M) Type of Bill;

(N) Principal Diagnosis Code (Current version of ICD codes at the time data is submitted);

(O) Other Diagnosis Codes (Up to 24 diagnosis codes can be submitted and reported. Current version of ICD codes at the time data is submitted);

(P) Procedure codes (Up to 24 procedure codes can be submitted and reported. Current version of HCPCS codes at the time data is submitted);

(Q) Reason for Visit (Current version of ICD or HCPCS codes at the time data is submitted);

(R) External Cause of Injury (E-codes), (if applicable) (Current version of ICD codes at the time data is submitted. Up to nine (9) E-codes can be submitted and reported);

(S) Related Cause Code, (if applicable) (Up to three (3) codes can be submitted and reported);

(T) Day of Week Patient is provided services code (Sunday = 1, Monday = 2, Tuesday = 3, Wednesday = 4, Thursday = 5, Friday = 6, Saturday = 7);

(U) Age group of patient;

(V) CRG Code (and associated codes if applicable);

(W) APG Code (Obtained from 3M APG Grouper) if applicable (Up to 10);

(X) APG Category Code (Obtained from 3M APG Grouper) if applicable (Up to 10);

(Y) APG Type Code (Obtained from 3M APG Grouper) if applicable (Up to 10);

(Z) Final APG Assignment Code (Obtained from 3M APG Grouper) if applicable (Up to 10);

(AA) Final APG Category Code (Obtained from 3M APG Grouper) if applicable (Up to 10);

(BB) APC Procedure Code (if applicable) (Up to 10);

(CC) APC Procedure Status Indicator Code (if applicable) (Up to 10);

(DD) APC Diagnosis Edits (if applicable) (Up to 10);

(EE) APC Procedure Code Edits (if applicable) (Up to 10);

(FF) APC Weight (if applicable) (Up to 10);

(GG) APC Base Procedure (if applicable) (Up to 10);

(HH) Clinical Classification Software Category Codes and associated codes, if applicable;

(II) Uniform Physician Identifier assigned to Rendering Physician or Rendering Other Health Professional;

(JJ) Uniform Physician Identifier assigned to Operating Physician or Other Physician or Other Health Professional;

(KK) Uniform Physician Identifier assigned to Other Provider or Other Health Professional;

(LL) Ancillary Service--Other Charges;

(MM) Ancillary Service--Pharmacy Charges;

(NN) Ancillary Service--Medical/Surgical Supply Charges;

(OO) Ancillary Service--Durable Medical Equipment Charges;

(PP) Ancillary Service--Used Durable Medical Equipment Charges;

(QQ) Ancillary Service--Physical Therapy Charges;

(RR) Ancillary Service--Occupational Therapy Charges;

(SS) Ancillary Service--Speech Pathology Charges;

(TT) Ancillary Service--Inhalation Therapy Charges;

(UU) Ancillary Service--Blood Charges;

(VV) Ancillary Service--Blood Administration Charges;

(WW) Ancillary Service--Operating Room Charges;

(XX) Ancillary Service--Lithotripsy Charges;

(YY) Ancillary Service--Cardiology Charges;

(ZZ) Ancillary Service--Anesthesia Charges;

(AAA) Ancillary Service--Laboratory Charges;

(BBB) Ancillary Service--Radiology Charges;

(CCC) Ancillary Service--MRI Charges;

(DDD) Ancillary Service--Outpatient Services Charges;

(EEE) Ancillary Service--Emergency Service Charges;

(FFF) Ancillary Service--Ambulance Charges;

(GGG) Ancillary Service--Professional Fees Charges;

(HHH) Ancillary Service--Organ Acquisition Charges;

(III) Ancillary Service--ESRD Revenue Setting Charges;

(JJJ) Ancillary Service--Clinic Visit Charges;

(KKK) Total Charges--Ancillary;

(LLL) Total Non-Covered Ancillary Charges;

(MMM) Total Charges;

(NNN) Total Non-Covered Charges;

(OOO) Encounter Identifier--a unique number for each encounter for the quarter;

(PPP) Service Line Revenue Code;

(QQQ) Service Line Procedure Code;

(RRR) HCPCS Procedure Code;

(SSS) HCPCS Procedure Modifiers (Up to 4 may be submitted and reported);

(TTT) Service Line Charge Amount;

(UUU) Service Line Unit Code;

(VVV) Service Line Unit Count;

(WWW) Service Line Non-Covered Charge Amount; and

(XXX) Patient Country (when the address is not in United States of America and confidentiality can be maintained).

(h) Release of public use data files.

(1) DSHS will make available a public use data file on electronic, magnetic or optical media for each quarter.

(2) DSHS shall release public use data from facilities that have certified the data as required by §421.76 of this title (relating to Certification of Compiled Event Data). A facility's failure to execute the certification form by the dates specified in 25 TAC §421.66(d) of this title (relating to Certification of Compiled Event Data), or election to not certify the discharge encounter data shall not prevent DSHS from releasing the facility's data if DSHS believes the data submitted is reasonably accurate and complete. DSHS may suppress for any quarter's data one or more data elements if deemed necessary to comply with provisions of the statute.

(3) If additional event claims (not previously submitted as specified in §421.65(b)(4) of this title (relating to Acceptance of Event Files and Correction of Data Content Errors), excluding replacement, adjustments and void/cancel claims, become available after the initial release of the public use data file for any quarter, DSHS will add the discharge claims, that are received on or prior to the dates specified in §421.63(a)(1) - (4) of this title (relating to Schedule for Filing Event Files) of the following quarter, to the public use data file and make the additional records available to the public.

(4) A public use data file which is disseminated to a requestor shall not be considered a report issued by DSHS as referenced in Health and Safety Code, §108.011(f), and requires no additional opportunity for the facility to review or comment on the data.

(5) With any public use data file prepared by the DSHS, DSHS shall attach all comments submitted by providers, which relate to any data included in the file. DSHS shall also make these comments available at DSHS offices and on the DSHS Internet site.

(i) An outpatient emergency visit event research data file may be released provided the following criteria are met:

(1) the DSHS Outpatient Emergency Visit Data Research Data File Request Form is completed and submitted to DSHS;

(2) the requestor has made payment according to DSHS' fee schedule;

(3) the Institutional Review Board reviews the research request and has determined the proposed research outcome can be achieved with the requested data;

(4) the Institutional Review Board grants authorization to the request or restricts access to specified data elements determined to be inappropriate for the research proposal in accordance with §421.10 of this title (relating to Institutional Review Board);

(5) the requestor agrees to dispose of the research data using authorized methods by the established end date stated on the written data use agreement; and

(6) the requestor has signed a written data use agreement.